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Bureau d	of Health Care Qua	lity and Compliance		Λ.	200	1281 11	/ FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMP			SURVEY LETED	
		NVN2536ADA		B. WING	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	03/2	29/2011
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
STEP 2,	NC .		3220 COR RENO, NV	ONADO WA 89503				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CO	DER'S PLAN OF COR PRECTIVE ACTION ERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 000	Initial Comment			D 000				
	by the Health Division prohibiting any cri- actions or other cl	conclusions of any invesion shall not be const minal or civil investiga laims for relief that ma arty under applicable f	trued as tions, y be					
	This Statement of Deficiencies was general result of the State Licensure survey control at your facility on 3/29/11. This State Licensure was conducted by the authority of 449.150, Powers of the Health Division. The facility is licensed for 16 residential beds for the treatment of abuse of alcoholdrugs. The census at the time of the surface of the		onducted censure of NRS program nol and irvey was files were		n.	APR 25 201 JIREAU OF HEALTH OF THE COMPLIA CARSON CITY NO	1 CARE INCE	
D 100 SS=D	All persons emplo documentation sh compliance with a	ysical Examinations byed in a facility must howing that they are in any applicable provision NAC concerning tuberon	ns of	D 100				
	NAC 441A.375 M dependent and he care: Managemei cases; surveilland counseling and particular and	is not met as evidence ledical facilities, facilities omes for individual resont of cases and suspecte and testing of employeeventive treatment. (Note that the dependent mutical for the dependent mutical facilities in a metal for the dependent mutical facilities.)	es for the sidential cted oyees; NRS cted case edical ust be					
f deficiencie	s are cited, an approve	d plan of correction must be	e returned wit	hin 10 days af	ter receipt of this	statement of defici-		(X6) DATE
ABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESEI	NTATIVE'S SIG	SNATURE	Dlace 1	Mokel!	C00	4/22/11
STATE FOR	M			6899 (QURB11		If contin	nuation sheet 1 of 9

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Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 03/29/2011 NVN2536ADA STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3220 CORONADO WAY STEP 2, INC **RENO, NV 89503** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRÉFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 100 D 100 Continued From page 1 managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage: and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is

Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 03/29/2011 NVN2536ADA STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3220 CORONADO WAY STEP 2, INC **RENO, NV 89503** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D 100 D 100 Continued From page 2 appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92; A by R084-06, 7-14-2006) Based on record review on 3/29/11, the facility did not ensure that 1 of 10 employees met the requirements of NAC 441A.375 concerning tuberculosis (TB) - (Employee #6 missing

Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/29/2011 NVN2536ADA STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3220 CORONADO WAY STEP 2, INC **RENO, NV 89503** PROVIDER'S PLAN OF CORRECTION (X5). SUMMARY STATEMENT OF DEFICIENCIES ID: (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 100 D 100 Continued From page 3 D 100 evidence of two-step TB test and physical First TB test administered on 4/19/11, examination). but HOPES nurse was unavailable to read results on 4/21/11. Employee #6 Severity: 2 Scope: 1 will attempt test again the week of May D 216 D 216 NAC 449.141(8) Health Services 2, 2011, as HOPES nurse is unavailable SS=F next week. 8. Clients of residential programs must undergo a tuberculin skin test that meets the requirements Employee #6 has doctor's appointment specified in chapter 441A of NAC. scheduled for Monday, April 25, 2011. Note will be provided at time of appointment. This Regulation is not met as evidenced by: NAC 441A.380 Admission of persons to certain medical facilities, facilities for the dependent or homes for individual residential care: Testing; respiratory isolation; medical treatment; counseling and preventive treatment; documentation. (NRS 441A.120). 1. Except as otherwise provided in this section, before admitting a person to a medical facility for extended care, skilled nursing or intermediate care, the staff of the facility shall ensure that a chest radiograph of the person has been taken within 30 days preceding admission to the facility. 2. Except as otherwise provided in this section, the staff of a facility for the dependent, a home for individual residential care or a medical facility for extended care, skilled nursing or intermediate care shall: (a) Before admitting a person to the facility or home, determine if the person: (1) Has had a cough for more than 3 weeks; (2) Has a cough which is productive; (3) Has blood in his sputum: (4) Has a fever which is not associated with a cold, flu or other apparent illness;

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Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/29/2011 NVN2536ADA STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3220 CORONADO WAY** STEP 2, INC **RENO, NV 89503** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 216 D 216 Continued From page 5 shall ensure that the person is evaluated at least annually for the presence or absence of symptoms of tuberculosis. 4. If the staff of the facility or home determines that a person has had a cough for more than 3 weeks and that he has one or more of the other symptoms described in paragraph (a) of subsection 2, the person may be admitted to the facility or home if the staff keeps the person in respiratory isolation in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200 until a health care provider determines whether the person has active tuberculosis. If the staff is not able to keep the person in respiratory isolation, the staff shall not admit the person until a health care provider determines that the person does not have active tuberculosis. 5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than three consecutive negative sputum AFB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease

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Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 03/29/2011 NVN2536ADA STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3220 CORONADO WAY** STEP 2, INC **RENO, NV 89503** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) D 216 D 216 Continued From page 6 D 216 in accordance with the recommendations of the Centers for Disease Control and Prevention for TB test results unavailable for client #1. the counseling of, and effective treatment for, a Client #1 was admitted to hospital due person having active tuberculosis. The to pregnancy complications shortly recommendations are set forth in the guidelines of the Centers for Disease Control and after entering treatment. Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. TB test results are unavailable for client The staff of the facility or home shall ensure that #2. Client #2 was admitted and counseling and preventive treatment are offered to each person with a positive tuberculosis discharged before any tests could be screening test in accordance with the guidelines administered, as HOPES nurse only of the Centers for Disease Control and provides testing services once per Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. week. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section 4/22/11
4/22/11
4/22/11 Attachment 1 = TB test results for client and the results thereof are documented in the #3 person 's medical record. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) Attachment 2= TB test results for client Based on record review on 3/29/11, the facility #4 did not ensure that 9 of 10 residents met the requirements of NAC 441A.380 concerning Attachment 3= TB test results for client tuberculosis - (Missing 2 step TB skin tests: Residents #2, #3, #7, #8 and #10); (Missing 2nd step TB skin tests: Residents #1, #4, #6, #9). Attachment 4= TB test results for client Severity: 2 Scope: 3 #6 D 250 D 250 NAC 449.147(6)(a-d) Dietary Services Attachment 5= TB test results for client SS=F 6. A facility with more than 10 clients must: Attachment 6= TB test results for client (a) Comply with all applicable provisions of chapter 446 of NRS and the regulations adopted #8 pursuant thereto: (b) Obtain the necessary permits from the Bureau Attachment 7= TB test results for client of Health Protection Services of the Health #9 Division: (c) Maintain a report of each inspection If deficiencies are cited, an approved plan of correction must be returned within 10 days afte Attachment 8= TB test results for client

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Bureau o	of Health Care Qua	lity and Compliance				<u> </u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLI IDENTIFICATION N			BER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
NVN2536ADA			B. WING		03/2	03/29/2011	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
STEP 2,	INC .		3220 COR RENO, NV	ONADO WA' 89503	Y		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 250	Continued From p concerning the sa 1 year after the da		D 250				
	(d) Maintain a repo	ort of each corrective a a deficiency noted in a graph (c) for at least 1	action report				e en
	Based on observa	s not met as evidence ation, interview and red , the facility failed to e with the standards of I	cord ensure the	-			
	Findings include:	en e	;		D 250 1A. Chicken was move	d to appropriate	3/29/4
	ready-to-eat roma	ns: vas stored next to and aine lettuce, broccoli, a GE select reach-in kito	and		location in the fridge a inspection. 1B. STEP2 needed to o	at time of	4/25/11
	b. No wash deter	gent was provided du kitchen dishwasher.	ring the		dishwasher/sanitizer. 4/21/11. Appliance w fully functioning no lat	ill be fixed and	010
	2. Cleaning and S	•		2A. STEP2 no longer al	lows the use of	3/39/11	
	a. Single use spo sanitizer next to the	chen sink.		sponges. Clients are s disposable towels and	* *	OF.	
	b. The cabinet un sink was heavily s linen, and other s	nder the 2-compartme soiled with kitchen det oiled materials.	ent kitchen oris, soiled		2B. Kitchen cabinet cle items removed. Please		4/22/11
		around both buildings necessary articles,	of Step 2,		9.		010

Bureau of Health Care Quality and Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/29/2011 NVN2536ADA STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3220 CORONADO WAY** STEP 2, INC **RENO. NV 89503** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 250 D 250 Continued From page 8 2C. Debris and unnecessary items non-functioning equipment, liter, and unorganized maintenance equipment. The areas observed removed from STEP2 property. See were the back of the property (south), around the attachments 10 and 11. utility shed, base of the driveway, and the eastside of the main house. 3A. Refrigerator repaired. See 3. Equipment and Maintenance Issues: attachment 12. a. The non-commercial GE select reach-in 3B. Currently, STEP2 cannot afford to refrigerator, located in the kitchen, was not replace existing appliance with properly closing at time of inspection. commercial grade appliances. b. Begin to replace all household grade However, STEP2's Board of Directors equipment used to store or prepare resident food and CEO are actively engaged in with commercial/NSF grade equipment. fundraising efforts to secure adequate c. A kitchen utensil drawer in the kitchen was in resources for a kitchen remodel. To disrepair and not properly closing. date, approximately \$1,500.00 has been Severity 2: Scope 3 raised for the kitchen remodel. 3C. Drawer repaired. Please see attachment 13.